Integration of Acute and Long Term Care (ALTC)
Phase 1
Frequently Asked Questions
Providers

What is Phase 1 of the Integration of Acute and Long Term Care (ALTC)?

Currently, more than 49,000 elderly and persons with disabilities have their health care needs successfully managed by one of five Medicaid contracted managed care organizations (MCOs) serving 110 localities across Virginia. However, once these recipients become eligible to participate in a home and community based waiver, they are moved out of a managed care environment into a fragmented fee for service environment with little or no coordination of their health care and long-term care needs. This disruption in care does not promote continuity of care for the enrollee and is costly for the Commonwealth.

Effective September 1, 2007, once a managed care enrollee is approved for enrollment into a Medicaid home and community based waiver (excluding those enrolled into the Technology Assisted Waiver), they will remain in their assigned MCO for their medical services, and transportation to medical appointments. Their home-and-community based care waiver services, including transportation to the waivered services, will be paid through the Medicaid fee for service program as a "carved out" service. This program change will prevent enrollees from having to change from their current MCOs for their medical care and will eliminate disruptions in care. Phase I will impact approximately 500 enrollees per year.

Which enrollees are impacted by this change?

This change will affect only Virginia Medicaid recipients already enrolled with a MCO who subsequently become enrolled into any of the following six home and community based waivers:

- HIV/Aids Waiver;
- Mental Retardation (MR) Waiver;
- Day Support Waiver;
- Elderly or Disabled with Consumer-Direction Waiver;
- Alzheimer's Assisted Living Waiver;
- Individuals and Families with Developmental Disabilities (DD) Waiver.

This change does not apply to:

- Recipients in the Technology Assisted Waiver
- Recipients placed in a waiver before becoming enrolled into managed care
- Dual Eligibles (receiving Medicare and Medicaid)
- HIPP Enrollees
- PACE Recipients
- Nursing Facility Residents
- FAMIS Enrollees

When will the program become effective?

Phase 1 will become effective September 1, 2007.

How will the process be different?

Under the new program, recipients will remain in their assigned MCO for their primary and acute medical care services. Their home and community based care waiver services will be carved out and paid through the Medicaid fee for service program.

Transportation to HCBW services will be provided by DMAS through the fee-for-service program. Transportation to acute and other health care services will continue to be the responsibility of the MCO.

The integration of the acute and long term care programs will take place as follows:

- Recipients enrolled in a MCO and who is subsequently enrolled into a HCBW (other than the Technology Assisted Waiver) with a start of care on or after September 1, 2007, will remain enrolled in the MCO.
- Recipients enrolled in a MCO as of September 1, who enroll in the Technology Assisted Waiver on or after September 1 will continue to be exempt from MCO enrollment.
- Recipients enrolled in a MCO as of September 1 but whose waiver enrollment is entered prior to September 1, will be exempt from managed care enrollment.
- Recipients who are not enrolled in a MCO (on or after September 1) at the time they enter HCBW services will remain exempt from managed care enrollment.

{Rule of thumb to remember – Recipient must be in a MCO prior to enrollment into a waiver before they can *maintain* their MCO enrollment.}

How will providers be able to identify these recipients?

This process should remain seamless for providers of acute and primary medical services. DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-

800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers also may contact the recipient's assigned MCO for eligibility verification.

How do recipients access transportation to medical and/or waiver services?

If the recipient needs transportation to a medical appointment, they should contact the number listed on their assigned MCO card.

If the recipient requires transportation to an approved waiver related service, they should contact LogistiCare at 1-866-386-8331.

Who do providers bill for services?

The MCO will continue to cover the same contracted medical services and transportation to contracted medical appointments. The current managed care carved out services (dental, school health, etc.), including the HCBW services will continue to be handled through fee-for-service.

DMAS fee-for-service will continue to pay for the waiver services and transportation to waiver services.

Is there any change to the prior authorization process?

No. Prior authorization (PA) will continue as follows:

- MCOs shall PA acute and primary medical care services, pharmacy related services, and transportation to medical appointments.
- KePRO shall process waiver enrollments and prior authorize services for the AIDS and EDCD waivers.
- DMAS shall process waiver enrollments for the DD waiver and KePRO shall prior authorize services for this waiver.
- DMAS shall process waiver enrollments and prior authorize services for the Alzheimers waiver.
- DMHMRSAS shall process waiver enrollments and prior authorize services for the MR and Day Support waiver.
- Doral Dental shall PA all dental related services.
- LogistiCare shall PA all waiver related services.
- PPL shall process consumer directed timesheets and payroll.

How will providers handle appeals?

The current appeals processes remain in place. Provider appeals shall be handled as follows:

- Acute and primary medical services denied by the MCO shall be appealed through the recipient's assigned MCO.

- Waiver services denied by KePRO shall be appealed through KePRO.

Enrollees shall follow the current process for appeals and enrollees shall still be allowed to appeal to the MCO and DMAS concurrently.

Who do providers call for help?

For questions related to acute and primary medical services, the provider should contact the recipients assigned MCO as noted on their medical ID card.

Providers should contact the DMAS Helpline for questions related to waiver services. The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

Questions about the program also may be sent via email to ALTC@dmas.virginia.gov. Information also is at the DMAS website at http://www.dmas.virginia.gov/altc-home.htm

In order to facilitate this transition, DMAS will hire two designated staff members to address any questions or issues that arise regarding authorization, coverage, and provision of services, and to work with the MCOs to coordinate care between providers and the MCOs.